

PATIENT HISTORY QUESTIONNAIRE page 2
Tomoka Eye Associates

Name: _____ Date of Birth: _____

Medical History: Do you currently or have you ever had problems in the following areas?
Please circle and explain

***Eyes**

- Cataracts N Y _____
- Halos around lights N Y _____
- Glare sensitivity N Y _____
- Macular Degeneration N Y _____
- Retinal Detachment N Y _____
- Diabetic damage N Y _____
- Glaucoma N Y _____
- Floater N Y _____
- Double vision N Y _____
- Crossed eyes N Y _____
- Flashing Lights N Y _____
- “Lazy” eye N Y _____
- Drooping eyelid N Y _____
- Migraine N Y _____
- Difficulty w/new RX N Y _____
- Difficulty w/eye drops N Y _____

***Gastrointestinal**

- Reflux/ Stomach ulcers N Y _____
- Colitis/ other N Y _____

***Endocrine**

- Diabetes N Y _____
- Thyroid Disease N Y _____

***Neurologic**

- Stroke N Y _____
- Other N Y _____

***Psychiatric**

- Depression N Y _____
- Anxiety/Other N Y _____

***Ears, Nose, Throat**

- Sinuses N Y _____
- Hay Fever/other N Y _____

***Bleeding Disorders**

- Easy Bruising N Y _____
- Coumadin Use N Y _____
- Other Blood Thinner use N Y _____
- Blood Transfusion? N Y _____

***Cardiovascular**

- High Blood Pressure N Y _____
- Heart Attack N Y _____
- Angina/Chest Pain N Y _____
- Heart Valve problems N Y _____
- Heart failure/ other N Y _____

***Immunologic**

- Rheumatoid Arthritis N Y _____
- Lupus/Other N Y _____
- Acquired immunodeficiency Syndrome N Y _____

***Respiratory/Lung**

- Asthma N Y _____
- Emphysema N Y _____
- Other N Y _____

***Other Illnesses not listed**

Date: _____ Reviewed by: _____

Doctor: _____